



WHAT'S NEW "OUT THERE"?



ACS COT Subcommittee on Performance Improvement and Patient Safety (SPIRIT)

(New) Purpose:

- Define quality in trauma care ("Green" Book)
- Provide practical techniques for monitoring and improving performance and patient safety in trauma care (Web-based Trauma PIPS manual, Optimal Trauma Center Organization and Management Course, TOPIC[®])
- Establish standards for the measurement of care processes linked to optimal outcomes (NTDB, TQIP, National Trauma Sample, NQF Taxonomy, PRQI, SCIP, etc.)



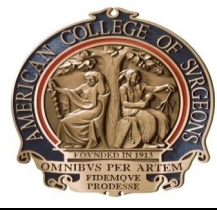
Transforming Trauma Center PI: From Peer Review to a Culture of Safety

- Adopting NQF & JCAHO patient safety taxonomy
 -
- Addressing “Harm” and “Error” in trauma care rather than “Preventability”:
 - Drill Down to issues
 - Quantify
- Applying Crew Resource Management (CRM) and Team STEPPS[®] measures in trauma care

SPIRIT Project task list:

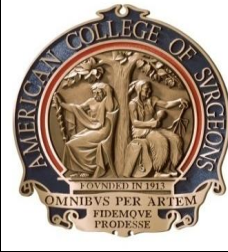


- VRC/ PI task force
- TOPIC collaborative
- Taxonomy & Terminology work group
- “Culture of Safety” work group
- Internet Resources &
Information Technology work group



Developing Level 4 & 5 Trauma Center Criteria

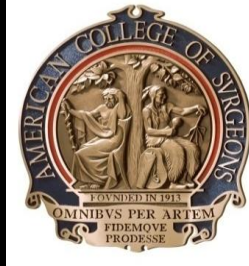
- Why?
 - States & centers are requesting criteria from the ACS
 - ACS needs to be internally consistent between systems, VRC, and the 'green book'
 - Level 3 centers without ortho can become 4s
 - Rural and critical access hospitals can be designated as 4s or 5s



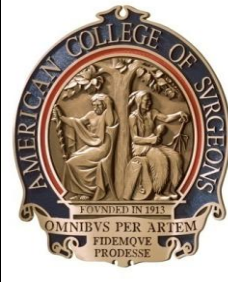
Developing Level 4 & 5 Trauma Center Criteria

- How?
 - The VRC & Systems committees have requested Level 4 & 5 criteria from all states known to support these levels
 - These are being tabulated
 - The 'most common' and 'most important' criteria will be identified
 - A system to evaluate them will be developed

Developing Level 4 & 5 Trauma Center Criteria



- When?
 - A draft will be vetted at the Clinical Congress in October 2010
 - There will be 1-2 rounds of public comment
 - The resulting criteria could be released by mid 2011



Resources for Optimal Care of the Injured Patient

Optimal hospital resources for care of the seriously injured

The responsibility for providing optimal hospital resources for the care of the seriously injured rests primarily with hospital trustees, administrators, physicians, and nurses. They must develop and regularly update personnel and a wide range of other resources required for optimal care. In particular, optimal resources encompass many areas and include medical and nursing staff, facilities, equipment, and medical technology, and an organized system for monitoring and evaluating the quality of care. Personnel must be available at all times, and resources must be available to all patients. Funding opportunities for monitoring and evaluation of staff physicians, nurses, and other health personnel, as well as regularly scheduled non-acute educational programs for community physicians and emergency physicians, must be provided, as well as audits and reviews and critiques of performance and non-performance services to all services, including trauma services. The role of the seriously injured, however, is not confined solely to the acute care phase of the patient's care. It includes the patient's care from the time of injury through the patient's recovery, rehabilitation, and long-term care, and the role of the hospital and its staff in the patient's care. The role of the hospital and its staff in the patient's care is not confined solely to the acute care phase of the patient's care. It includes the patient's care from the time of injury through the patient's recovery, rehabilitation, and long-term care, and the role of the hospital and its staff in the patient's care.

The role of the hospital and its staff in the patient's care is not confined solely to the acute care phase of the patient's care. It includes the patient's care from the time of injury through the patient's recovery, rehabilitation, and long-term care, and the role of the hospital and its staff in the patient's care.

Hospital and Prehospital

for Optimal Care of the Injured Patient and Appendices A through J

AMERICAN COLLEGE OF SURGEONS

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT



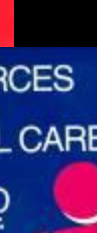
COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT: 1999



COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT: 1993



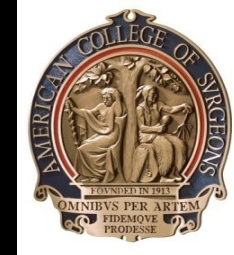
COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT 2006

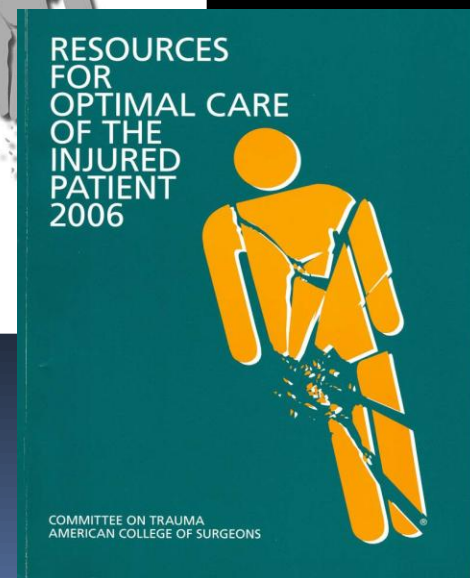
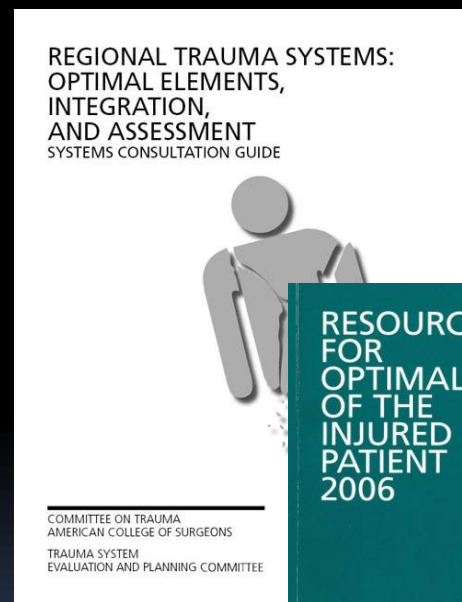


COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

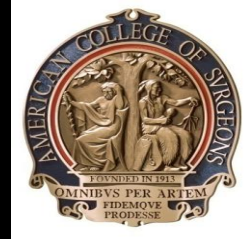
Updating the Green Book



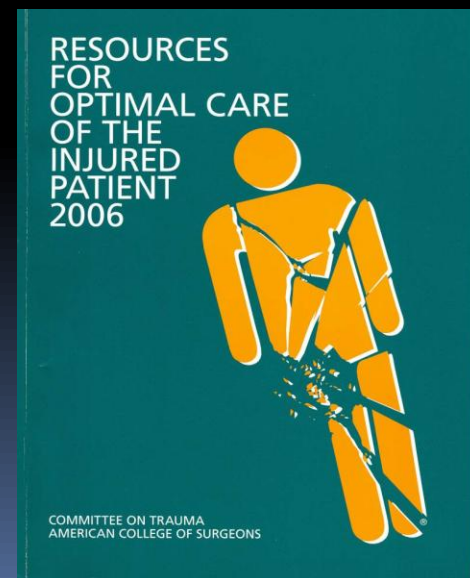
- Why?
 - It is already 5 years old
 - The 'Green Book' and the Systems document need to dovetail
 - The VRC is undergoing a re-engineering project



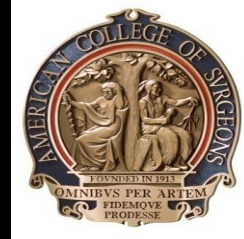
Updating the Green Book



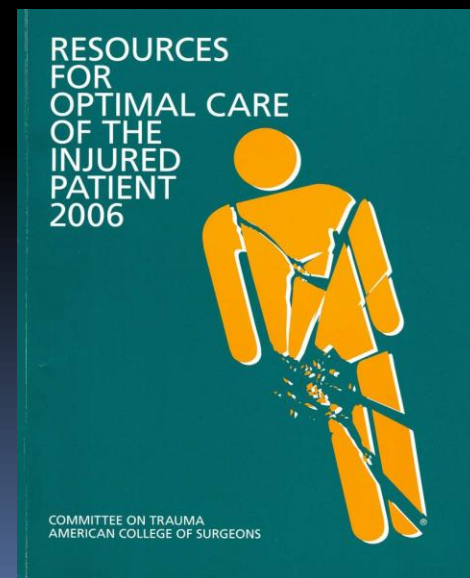
- How?
 - A strategic planning committee has been formed to design the process
 - A multidisciplinary & evidence base approach will be used
 - R. Stephen Smith, MD, FACS will work group



Updating the Green Book



- How?
 - A website will be created to receive & catalog requests for changes
 - Evidence must be submitted
 - Levels of evidence assigned
 - Chapter authors create a draft
 - Multidisciplinary review
 - Public comment
 - Publication




Understanding the Patient Safety Framework - Surveillance


■ Surveillance Strategies

- **Sentinel Events** - rare event where there are system failures such as wrong medication dosage for geriatric patient, wrong blood products, wrong sized device for pediatric patient, etc.
- **Trigger events** - pre-defined events where specific chart reviews including sampling are conducted such as readmission to ED, oversedation, use of Narcan, average defibrillation time, etc.
- **Rate events** - includes a numerator and denominator, i.e., CLABSIs – Central Line Associated Blood Stream Infections where numerator = number of events divided by number of central line days in ICU.




Patient Safety Framework

- Risk vs severity
 - Weight as to impact
 - Focus on increased impact/severity
 - Opportunities for improvement
 - Improvement strategies
 - Data-driven to counter anecdotal experience
“only as good as our last bad experience”
- 



Understanding the Patient Safety Framework

- Improvement Strategies
 - **Risk reduction** - Falls
 - **Standardization** – Colors of wrist band
 - **Safeguards** – Sensors in vehicles for backing up
 - **Safety check lists** – Surgical/Aviation check lists
 - **Force functions** – Foot on brake before car will engage
 - **Communication protocols** – structured processes – Read back for orders
 - **Simulations** – hands on practice not just “education and training”
 - **Technologies** – Auto alerts, GPS/cell phones, Side air bags, car crumpling, etc.
- 



Western States

- Regional PI benchmarks so we can compare MT to other states
 - Use PM study conclusions as “Golden Few” priorities
 - Even worst outcomes have opportunities for improvement
- 